Clear Form Entries

SOUTH CAROLINA DEPARTMENT OF DISABILITIES AND SPECIAL NEEDS

Rehabilitation Supports

CONTRACT AMENDMENT REQUEST FORM OF INDIVIDUAL REHABILITATION SUPPORTS

Please Type or Print

PROVIDER: _____ DATE: _____

CONTRACT ALLOCATION: _____ CONTRACT NO. OF UNITS: _____

CONTRACTED NO. OF INDIVIDUALS TO BE SERVED: _____

PROPOSED NO. OF INDIVIDUALS TO BE SERVED *: _____

PROPOSED ACTION: *(check one)*

☐ Replace an individual no longer receiving/needing services. (No new units or funding)

☐ Increase number of individuals with additional units and funding.

PROPOSED EFFECTIVE DATE FOR ABOVE REQUESTED ACTION: _____

JUSTIFICATION:

names of persons no longer receiving service	names of persons added	anticipated date services begin

Are 250 units available to each person added to this contract? ☐ YES ☐ NO

(If "No" is marked, explain the circumstance and number of units needed to provide each person with 250 units in the next 12 months)

Signature: _____ Date: _____

(Executive Director)

* The proposed number of individuals to be served must be the cumulative number of different individuals to be served under the Contract during the contract period. Each person has up to 250 units available to them in 12 months after the services begin date.

The completed form, signed and dated is forwarded to the appropriate Central Office finance Division for processing.